wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

End Stage Renal Disease Service Providers

HMOs and Other Managed Care Programs

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

Changes to local codes and paper claims for end stage renal disease services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for end stage renal disease (ESRD) services, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 (CMS 1450) paper claim instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for end stage renal disease (ESRD) services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., documentation requirements), but include:

- Adopting nationally recognized revenue codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 (CMS 1450) paper claim instructions.

Note: Use of the newly adopted national codes and revised paper claim instructions prior to implementation dates may result in claim denials. Specific implementation dates will be published in a future *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for ESRD services.

Nationally recognized revenue codes

Wisconsin Medicaid will adopt nationally recognized four-digit revenue codes to replace currently used three-digit local codes for ESRD services. Providers will be required to add a preceding "0" to the current three-digit revenue code when submitting claims for ESRD services. For a complete list of revenue codes, refer to the National UB-92 Uniform Billing Manual. Providers must use the appropriate revenue code that describes the service performed.

Providers should continue to refer to their service-specific *Updates* for other nationally

recognized procedure codes that Wisconsin Medicaid covers.

Coverage for end stage renal disease services

Medicaid coverage and documentation requirements for ESRDs remain unchanged. Refer to ESRD *Updates* for complete Medicaid policies and procedures.

Medicare disclaimer M-6 no longer valid

Previously, ESRD providers were instructed to use M-6 in the following two instances when billing for services related to chronic renal failure:

- A recipient is not eligible for Medicare benefits *and* cannot become eligible for Medicare benefits.
- A recipient may not be eligible for Medicare benefits in the first three months of dialysis treatment.

With the implementation of HIPAA, Medicare disclaimer M-6 will no longer be a valid code. Providers should refer to Attachment 1 of this *Update* to determine the appropriate Medicare disclaimer code usage.

Revision of UB-92 paper claim instructions

With the implementation of HIPAA, Medicaid-certified ESRDs will be required to follow the revised instructions for the UB-92 paper claim form in this *Update*, even though the actual UB-92 claim form is not being revised at this time. Refer to Attachment 1 for the revised instructions. Attachment 2 is a sample of a claim for ESRD services that reflects the changes to the billing instructions.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the UB-92 claim form instructions

Revisions to the UB-92 paper claim form instructions include the following:

- Revenue codes revised (Form Locator 42).
- HCPCS/Rates revised (Form Locator 44).
- Prior payments revised (Form Locator 54 A-C & P).
- Medicare and other insurance disclaimer codes revised, including the elimination of M-6 (Form Locator 84 a-d).

Medicaid-certified ESRDs will be required to follow the revised instructions for the UB-92 paper claim form in this *Update*, even though the actual UB-92 claim form is not being revised at this time.

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

ATTACHMENT 1
UB-92 (CMS 1450) claim form instructions for end stage renal disease services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the Form Locator descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required form locators as appropriate. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC Web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card when initially determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — ERO Assigned Number (required, if applicable)

Enter the Pre-Admission Review control number as required.

Form Locator 3 — Patient Control No.

Providers can enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locator 4 — Type of Bill

Enter bill type 721.

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through)

Enter the first date of service (DOS) in the "from" column and the last DOS in the "through" column. The dates may not span more than one calendar month. Enter both dates in MM/DD/YY format (e.g., January 2, 2004, would be 010204).

Form Locator 7 — Cov D.
Enter the total number of days covered by the primary payer, as qualified by the payer organization.

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (not required)

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name
Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src (not required)

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

Form Locator 23 — Medical Record No. (not required)

Form Locators 24-30 — Condition Codes (not required)

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — Occurrence Code and Date (not required)

Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.

Enter the appropriate national four-digit revenue code. Enter revenue code "0001" on the line with the sum of all the charges.

Form Locator 43 — Description

Enter the DOS in MM/DD/YY format in Form Locator 43 or Form Locator 45.

When series billing (i.e., billing from two to four DOS on the same line), indicate the DOS in the following format: MM/DD/YY MM/DD MM/DD MM/DD. Indicate the dates in ascending order. Providers may enter up to four DOS for each revenue code if:

- All DOS are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four DOS per revenue code, indicate the dates on the subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim including the "Total Charges" line.

Form Locator 44 — HCPCS/Rates

Enter the single most appropriate procedure code for every revenue code on every outpatient claim except revenue code "0001" in Form Locator 44.

Form Locator 45 — Serv. Date

Enter the DOS in MM/DD/YY format in Form Locator 45 or Form Locator 43. Multiple DOS must be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of covered visits, where appropriate.

Form Locator 47 — Total Charges

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, "statement covers period." Enter revenue code "0001" to report the sum of all charges in Form Locator 47.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer

Enter all health insurance payers here, including Medicare. For example, enter "T19" for Wisconsin Medicaid and/or the name of commercial health insurance.

Form Locator 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Form locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C & P — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due (not required)

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured's Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — ESC (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.

Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" codes.

Form Locators 68-75 — Other Diag. Codes (not required)

Form Locator 76 — Adm. Diag. Cd. (not required)

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Form Locator 80 — Principal Procedure Code and Date (not required)

Form Locator 81 — Other Procedure Code and Date (not required)

Form Locator 82 a-b — Attending Phys. ID (not required)

Form Locator 83 a-b — Other Phys. ID (not required)

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial health insurance billing information

Commercial health insurance coverage must be billed prior to billing Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

When the recipient has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, ***and*** the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes ***must*** be indicated in Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Medicare information

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.

Code	Description
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

ATTACHMENT 2

Sample UB-92 claim form — End stage renal disease

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234	2	3 PATIENT CONTROL NO. 1234JCD	4 TYPE OF BILL 721
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 010404	THROUGH 012504	7 COV D. 4
8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME RECIPIENT, IMA H.	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	26	28	30	31

	32 CODE	32 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a								A
b								B
								C

	38	39 CODE	39 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a					
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300		82340		3	XXX XX		1
2	0300		82570		2	XXX XX		2
3	0300		83945		1	XXX XX		3
4	0821	010404 0111 0118 0125	90935		4	XXX XX		4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22	0001	TOTAL CHARGES				XXXX XX		22
23								23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	45009 BLUE CROSS	BC111			XXXX XX		
B	MEDICARE	123456789			0 00		
C	T19 MEDICAID	87654321					
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C			1234567890		

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
5920							

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
					OTHER PHYS. ID

	84 REMARKS
a	
b	OI-P
c	M-7
d	

85 PROVIDER REPRESENTATIVE
X *Ima H. Provider*

86 DATE
020104

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 **OCR/Original**